

Location: Office

Vitals: Her temperature is 36.7C(98F), blood pressure is 120/76 mm Hg, pulse is 80/min, and respirations are 14/min.

HPI:

A 45-year-old white female presented to the office because of fatigue and exertional shortness of breath for the past two months. The symptoms are getting worse. She denies any chest pain, orthopnea, PND, leg swelling, palpitation, syncope, cough, and weight loss. She has no constipation or diarrhea. She has not looked at her stools for melena, but she denies any blood in the stools. The only other problem is some epigastric discomfort for which she usually takes over-the-counter antacids. She takes no other medication. Her menstrual cycles are always regular and last 3-4 days each time. She has no other medical problems. She smokes one pack of cigarettes for the past 20 years. Occasionally, she drinks alcohol and does not use recreational drugs. Her sister has asthma; otherwise, her family history is not significant. She has no known drug allergies. The last Pap smear, pelvic exam, and breast exam done one year ago was normal. The rest of the ROS is negative.

How would you approach this patient?

We have a very healthy 45-year-old female presenting with fatigue and exertional dyspnea. The only other problem that she has is epigastric discomfort. At this point, the DD is broad. Physical exam and basic labs will narrow the DD.

Order physical exam:

Complete physical exam

Results:

The patient appears comfortable. There is no lymphadenopathy. Pallor is present on exam. Lungs and heart are clear to auscultation. Abdomen is soft, but very mild discomfort to deep palpation is noted in the epigastric region. Extremities are normal. The rest of the exam is normal.

Order:

FOBT (fecal occult blood testing), stat
CBC with diff, stat
BMP, stat
UA, stat
CXR, PA/lateral, stat

Results:

FOBT is positive. CBC shows Hb of 8.0 g/dL, MCV 72 fl, WBC of 6,000/cmm with normal differential, platelet count of 220,000/cmm. Peripheral smear showed hypochromic and microcytic anemia. BMP showed a BUN of 25 and Cr of 1.1. UA is normal. CXR is normal. The rest of the labs are normal.

*Now, we can say that the patient's most likely reason for fatigue and shortness of breath is from anemia. The cause is most likely due to bleeding from the GI tract. Since the patient has some epigastric discomfort, we can start with an upper GI endoscopy.

Order:

Admit to ward/Floor
NPO
Ambulation at will
Serum Iron, routine
Serum ferritin, routine
TIBC, routine
Type and cross match for blood, stat
Transfuse PRBC, stat

Omeprazole, oral, continuous
PT/PTT, stat

*Advance clock for 12 hours (to give adequate time for NPO)

Upper GI flexible endoscopy, routine
Helicobacter pylori biopsy, stomach, routine (or) H. pylori serology, routine
Consent for procedure
Recheck Hb next day

Results:

Serum iron and ferritin are low. TIBC is elevated. Endoscopy showed clean-based, non-bleeding duodenal ulcer. Biopsy for H. Pylori is positive.

Order:

Clarithromycin, oral, continuous
Amoxicillin, therapy, oral, continuous
Iron, therapy, continuous
Vitamin C, therapy, continuous (increases Iron absorption)
Iron-enriched diet

No aspirin

Counseling:

Patient counseling
No smoking
No alcohol
Drive with seat belts
Regular exercise
Safe sex

*Change the location to home. Follow-up in two weeks

Primary diagnosis:

Duodenal ulcer

Discussion:

In general, whole blood or serum serology is a most cost-effective test to identify H. pylori in symptomatic patients. However, if the patient is undergoing endoscopy, then endoscopic biopsy can be performed. The regimen of choice for H. Pylori eradication is triple therapy with a proton pump inhibitor, Clarithromycin, and Amoxicillin for about two weeks. Once the treatment is completed, confirmation of eradication is recommended. Urea breath testing is the test of choice for this purpose.

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